

REPORTING AND PROCESSING MEDICAL MATERIEL COMPLAINTS/ QUALITY IMPROVEMENT REPORT				DATE	
				NO.	
TO		FROM			
TYPE OF COMPLAINT ►		1A. FOR DOD USE <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III		<input type="checkbox"/> QUALITY COMPLAINT <input type="checkbox"/> NEW ITEM <input type="checkbox"/> SIMILAR ITEM	
2. MFG. STOCK NO.		3. ITEM DESCRIPTION			
4. NAME AND ADDRESS OF MANUFACTURER			5. NAME OF CONTRACTOR (If other than the manufacturer)		
			6. CONTRACT NO. OR PURCHASE ORDER NO.		
7. LOT NO.		8. CONTROL NO.		9. MANUFACTURER'S SERIAL NO.	
				10. MODEL NO.	
11. DATE MANUFACTURED		12. DATE PACKED		13. EXPIRATION DATE	
14. SOURCE (Direct or Distributor)		15. QUANTITY ON HAND		16. QUANTITY SUSPENDED	
COMPLETE ITEM 17A. THROUGH 17F. FOR DOD TYPE I COMPLAINTS ONLY					
17A. TOTAL NO. PATIENTS INVOLVED		17B. TOTAL NO. REACTIONS		17C. SEVERE OR UNUSUAL REACTIONS	
17D. REACTIONS REQUIRING HOSPITALIZATION		17E. LENGTH OF HOSPITALIZATION		17F. VACCINE <input type="checkbox"/> INITIAL <input type="checkbox"/> BOOSTER INTERVAL _____	
18. CAUSE OF COMPLAINT (Explanation of unsatisfactory condition, deficiency, or description of reaction. Complete 18 through 21 for ALL complaints.)					
19A. TYPED NAME OF INITIATOR (For Type I MC/DC/NC)			19B. AUTOVON/FTS TELEPHONE NO.		19C. COMMERCIAL TELEPHONE NO.
20A. TYPED NAME OF SUPPLY OFFICER			20B. SIGNATURE OF SUPPLY OFFICER		20C. DATE
20D. AUTOVON/FTS TELEPHONE NO.			20E. COMMERCIAL TELEPHONE NO. AREA CODE ()		

REPORTING AND PROCESSING MEDICAL MATERIEL COMPLAINTS/QUALITY IMPROVEMENT REPORT *(Continued)*

21. RECOMMENDATIONS AND/OR ADDITIONAL REMARKS

22. ACTION TAKEN

23. NAME *(Action Officer)*

24. TITLE AND ORGANIZATION

25. DATE